# Becket Systems
**An Independent Review Organization**
**815-A Brazos St #499**
**Austin, TX 78701**
**Phone: (512) 553-0360**
**Fax: (207) 470-1075**
**Email: manager@becketsystems.com**

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/14/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 80 hours 10 sessions of work hardening program

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO, Board Certified Physical Medicine and Rehabilitation

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ X ] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.**

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. She xxxx. She reported an injury to her right knee and low back. Behavioral evaluation report dated xxx indicates that the patient completed a physical therapy course and was released to work at light duty capacity. BDI is 17 and BAI is 0. Diagnoses are adjustment reaction and pain disorder associated with both psychological factors and a general medical condition. Functional capacity evaluation dated xxxx indicates that current PDL is sedentary-light and required PDL is heavy.

Initial request for work hardening x 80 hours was non-certified on xxxx noting that the documented BDI and BAI scores are not significantly elevated to support a medical necessity for such an extensive return to work program. Request for reconsideration dated ssss indicates that the patient has demonstrated good compliance and improvement with her treatment, and her progress has not plateaued. The denial was upheld on appeal dated ssss noting that the patient was given a 0% impairment rating. The reconsideration letter does not address the issues of the BAI and BDI scores. Average pain level is 2. BDI =17 mild depression. BAI = 0 no anxiety. Has elevated FABQ score. Cannot determine coefficients of variation in functional capacity evaluation. Letter dated ssss indicates that since the onset of her injury she has become deconditioned.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained injuries on xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The number of physical therapy visits completed to date is not documented. There are no serial physical therapy records submitted for review documenting that the patient has completed an adequate course of physical therapy with improvement followed by plateau as required by the Official Disability Guidelines. In fact, the reconsideration letter datedxxxx and xxxxx state specifically that the

patient has improved with her treatment and her progress has not plateaued. The patient does not appear to present with a significant psychosocial component which would require a multidisciplinary program. As such, it is the opinion of the reviewer that the request for 80 hours 10 sessions of work hardening program is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**

**[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**

**[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

**[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**

**[ ] INTERQUAL CRITERIA**

**[ X ] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

**[ ] MILLIMAN CARE GUIDELINES**

**[ X ] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**[ ] TEXAS TACADA GUIDELINES**

**[ ] TMF SCREENING CRITERIA MANUAL**

**[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**